

Patient InformationDOCTOR OF RECORD
Andrew E Park MD**TSC**

PATIENT NAME (First Name, Middle Initial, Last Name) Robert Plock		PATIENT ID (Office Use Only) 42157	Mobile (214) 799-7775	Work (214) 275-4195	THIRD PHONE (MOBILE)
ADDRESS 6827 Latta Parkway		DATE OF BIRTH 07/26/1968	SOCIAL SECURITY NUMBER 456-53-3292	SEX (M or F) [X]M []F	MARITAL STATUS [X]Married []Single []Other
CITY, STATE, ZIP Dallas, TX 75227		AGE 45 yrs	EMERGENCY CONTACT PERSON Abner, Clarence	RELATIONSHIP TO PATIENT Acquaintance	CONTACT PHONE (214) 799-7774
EMPLOYER Spencer A/C Heating		OCCUPATION HVAC Tech		PATIENT E-MAIL ADDRESS	
REFERRING DOCTOR NAME & ADDRESS Christensen M.D., William T 3434 Swiss Ave, Suite 206 Dallas, TX 75204 (214) 828-5775 (214) 828-5777					
PRIMARY CARE DOCTOR NAME & ADDRESS					
RACE		ETHNICITY			

Responsible Party

RESPONSIBLE PARTY NAME (First Name, Middle Initial, Last Name) Robert Plock		Mobile (214) 799-7775	Work (214) 275-4195	THIRD PHONE (MOBILE)
ADDRESS 6827 Latta Parkway		DATE OF BIRTH 07/26/1968	SOCIAL SECURITY NUMBER 456-53-3292	
CITY, STATE, ZIP Dallas, TX 75227		SEX (M or F) [X]M []F	PATIENT'S RELATION TO RES SELF	
EMPLOYER Spencer A/C Heating		OCCUPATION HVAC Tech	RESP PARTY ID (Office Use Only) 44032	

Primary InsuranceWHO IS THE PRIMARY INSURED PARTY (CHECK ONE)
☒ Patient (same as above) ☐ Responsible Party (same as above) ☐ Other (complete below)

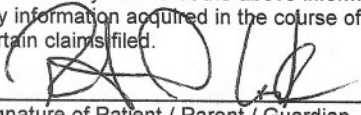
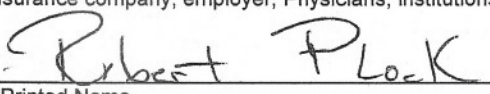
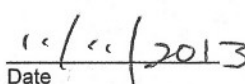
INSURANCE COMPANY NAME United Healthcare - UMR	COPAY AMOUNT \$40 Co-Pay	INSURED'S NAME (First Name, Middle Initial, Last Name) (Same as Patient)		
INSURANCE COMPANY ADDRESS P.O. Box 30541		INSURED'S ADDRESS, CITY, STATE, ZIP		
INSURANCE COMPANY CITY, STATE, ZIP Salt Lake City, UT 84130		INSURED'S DATE OF BIRTH	PRIMARY PHONE (HOME)	SECONDARY PHONE (WORK/CELL)
INSURANCE COMPANY PHONE NUMBERS Home (888) 339-7280		INSURED'S SOCIAL SECURITY NO.	INSURED'S SEX (M or F)	PATIENT'S RELATION TO INSURED
INSURED'S POLICY NUMBER 13280912	INSURED'S GROUP # 76-410892	INSURED'S EMPLOYER		INSURED'S OCCUPATION

Secondary InsuranceWHO IS THE SECONDARY INSURED PARTY (CHECK ONE)
☐ Patient (same as above) ☐ Responsible Party (same as above) ☐ Other (complete below)

INSURANCE COMPANY NAME		INSURED'S NAME (First Name, Middle Initial, Last Name)		
INSURANCE COMPANY ADDRESS		INSURED'S ADDRESS, CITY, STATE, ZIP		
INSURANCE COMPANY CITY, STATE, ZIP		INSURED'S DATE OF BIRTH		
INSURANCE COMPANY PHONE NUMBERS		INSURED'S SOCIAL SECURITY NO.	INSURED'S SEX (M or F)	PATIENT'S RELATION TO INSURED
INSURED'S POLICY NUMBER	INSURED'S GROUP #	INSURED'S EMPLOYER		INSURED'S OCCUPATION

Authorization and Acknowledgement

I / We hereby state that the above information is true and correct to the best of my / our knowledge. I / We authorize the above named practice to release any information acquired in the course of my treatment to my insurance company, employer, Physicians, institutions or third party payors, as required for certain claims filed.


Signature of Patient / Parent / Guardian
Printed Name
Date

I / We authorize direct payment to be made to the above named practice for any and all medical or surgical services rendered. I understand if any services or charges are not covered by my insurance carrier or my eligibility can not be verified, I am responsible for all charges incurred.

Signature of Patient / Parent / Guardian / Insured_____
Printed Name_____
Date